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| --- | --- |
| **First Name:** Click here to enter text. | **Surname/ Last Name:**Click here to enter text. |
| **Date of birth:** Click here to enter a date. | **NHS Number:**Click here to enter text. |
| **Address:**Click here to enter text.**Postcode**Click here to enter text. | **GP Name:** Click here to enter text.**GP Address:** Click here to enter text. |
| **Preferred title:** Choose an item. | **GP telephone:**Click here to enter text. |
| **Mobile Number :**Click here to enter text.**Other Numbers :**Click here to enter text. | OK to send texts to mobile phone: Choose an item. |

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| Interpreter Needed: Choose an item. Preferred Language:Click here to enter text. | **Blood Pressure:** Click here to enter text. **/**Click here to enter text.Heart Sounds: Choose an item. |
| First Day of Last PeriodClick here to enter a date.: | Number of previous deliveries/ births:Click here to enter text. | Reasons if Booking after 12 weeks pregnant:Click here to enter text. |

**Previous History – Information to help maternity services plan care (✓ where relevant):**

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| --- | --- | --- |
| **Pregnancies**[ ] Having First baby[ ] Other pregnancies normalOr[ ] Caesarean Section[ ] Premature Baby[ ] Previous Womb Surgery[ ] Pre-Eclampsia /Eclampsia[ ] Postnatal depression[ ] 3 or more miscarriages[ ] Miscarriage after 13 weeks[ ] Baby born with abnormality[ ] Shoulder Dystocia[ ] Placenta Accreta[ ] Stillbirth[ ] Neonatal death[ ] **Other Maternity Problems:** Click here to enter text. | **History**[ ] High Blood Pressure[ ] Diabetes[ ] Other Hormone disorder[ ] Epilepsy[ ] Heart disease[ ] Kidney disease[ ] Liver disease[ ] Severe Asthma[ ] Blood Clotting Disorder[ ] Autoimmune Disease[ ] Deep Vein Thrombosis[ ] Tuberculosis[ ] Haemoglobin disorder[ ] Psychiatric illness including[ ] Depression/Anxiety[ ] **Other Medical/Surgical problems:** Click here to enter text.[ ] None of the above | **Information**[ ] Smoker[ ] Alcohol/ Substance Misuse[ ] Domestic Abuse[ ] Learning Disability[ ] FGM[ ] Safeguarding concernsHas a Social Worker: Choose an item.Social Worker name if known: Click here to enter text.**Other relevant social/ domestic circumstances**:Click here to enter text.[ ] None of the above**Current Medication:** Click here to enter text.**Allergies:**Click here to enter text.  |

[ ] Please tick if you are booking your own pregnancy directly Date: Click here to enter a date.

**Please email completed form to**: **bhnt.wxantenatalreferrals@nhs.net**

**PLEASE NOTE: on your first appointment you will need to provide proof of address, Identity & NHS Number**